PrEP Should Be a Fast Idea, Not a Slow One

October 7, 2013 By David Evans

The brilliant surgeon and author Atul Gawande recently wrote in The New Yorker about “slow ideas,” ingenious new ideas that are slowly or never accepted while others flourish quickly. His article made us think instantly of pre-exposure prophylaxis (PrEP), a new and promising strategy to prevent HIV infections.

Gawande’s example of the slow adoption of an idea was the difference between the adoption of anesthesia and the adoption of antiseptics in the mid 1800s. With anesthesia, people could be sedated during surgery, which benefited the surgeon as much as the patient. The idea took mere weeks to become a global phenomenon and enter into wide use. Conversely, antiseptic practices, which were burdensome for surgeons and acted against an invisible foe (bacteria) that might or might not cause death, took years to catch on. We write this blog post out of fear that without a significant shift in thinking about HIV prevention, PrEP will be a slow idea, resulting in thousands of people unnecessarily becoming infected with HIV.

PrEP involves the use of any anti-HIV agent before, during and usually after sex to prevent infection. Today, PrEP refers primarily to taking the HIV treatment Truvada every day along with using condoms. What we know about PrEP is that even in people who don’t use condoms regularly, it can work amazingly well if taken exactly as prescribed. Two studies have found that daily use could be almost 100-percent effective.

We don’t yet know fully what the acceptance of PrEP will be among men who have sex with men (MSM). Granted, PrEP is far more expensive than a bucket of condoms in a bar’s bathroom. Studies are just beginning to determine its impact outside clinical trials and whether PrEP can easily or adequately be provided in real-world settings.

What we do know, however, is that very few MSM, and far fewer exclusively heterosexual people, even know about it. And we also know that very few providers have prescribed it -- some of them only reluctantly -- even though they are seeing patients who could clearly avoid infection as a result of using it.

Even though Truvada as PrEP was approved by the FDA last summer, only about 1,700 people in the United States have taken it outside carefully controlled research projects. Given that roughly 50,000 people, most of them MSM, become infected every year, this is far too few to make a dent

in the epidemic, and that's extremely unfortunate.

We are not arguing that everyone should start taking Truvada any more than we are arguing that people should abandon condoms. Rather, what we are saying is that, despite modern antiretroviral therapy, HIV is an expensive, stigmatizing and challenging disease to treat. HIV-positive people risk side effects from long-term treatment and the low levels of virus that continue to reproduce despite that treatment. Any new case of HIV infection averted is beneficial for the individual and society as a whole. Every meaningful opportunity to prevent a case of HIV infection should be greeted with pleasure. The opportunity to implement PrEP should be met with great excitement and a sense of urgency.

We can endlessly wish or expect that people will consistently use condoms in order to prevent HIV infections from occurring, but it is unrealistic and dangerous to think that we will ever effectively guarantee this. Rates of unplanned pregnancy are evidence enough that people are not always in perfect control of their sexual behavior in the face of love, lust or even pressure.

Some HIV care providers and prevention workers appear to be acting as gatekeepers for PrEP, out of a belief that condoms should be enough to stop the epidemic, or out of concern that this intervention will further decrease condom use. Recent cases we are aware of make this plain, where doctors who should know better refuse to give PrEP to those who need it.

Also, comments on blogs reacting to people describing their PrEP use have been accusatory and absolutely reprehensible, essentially a new version of slut shaming. Many of these same critics who condemn PrEP users would vigorously argue that women have an unfettered right to choose the form of birth control method that best suits them, and that providers have no right to impose their personal views on such intensely personal decisions.

We do not have the luxury of allowing PrEP to become a "slow idea" that takes years to be implemented, or -- as with its sister intervention, post-exposure prophylaxis (PEP), which is emergency treatment after exposure -- never really gets implemented at all. We have known for nearly two decades that people exposed to HIV are far less likely to become infected if they immediately take a course of antiretroviral therapy for about a month. Yet a hospital in New York City recently spent hours dithering over whether to offer this intervention to a man who had definitely been exposed to the virus.

One of Gawande's suggestions for speeding up the adoption of new technologies is an "each one teach one" approach, whereby people engage with others to help spread the new idea. We hope that you, the reader, will become knowledgeable about PrEP, not just for yourself but in order to suggest consideration of it by people you care about who might otherwise become HIV-infected. We hope that if you see articles or blog posts in which people honestly describe their positive motivations to use PrEP, you will praise them for acting responsibly rather than condemning them for doing something transgressive. We hope that you will join with us to support the right of HIV-negative people to choose which forms of prevention they use. And we hope you will tell your providers about PrEP and its promise and encourage them to offer it to patients who might benefit from it.

More information about PrEP and short videos about it are available at www.projectinform.org/prep or www.myprepexperience.blogspot.com.

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